HSBC Life 滙豐保險

EB34

CLAIM FORM 索償表格

Group Life Scheme - Hospital Cash Benefit 團體人壽計劃 – 住院現金保障索償

To be filled in by members who were admitted to hospital and wish to claim the cash benefit. 由曾入院及擬申請現金福利的成員填寫。由受保僱員或病人和醫生填寫。

HOW TO SUBMIT THIS FORM 如何提交此表格

After completing the form please send back to us:
填寫表格後，請發回給我們：

BY MAIL
Post the fully completed and signed claim form (sections 1 & 2), plus all the items in the checklist, to Employee Benefits Claims, HSBC Life, P.O. Box 70451, Kowloon Central Post Office, Kowloon, Hong Kong

郵寄
將填妥並已簽署的索償表格（第 1 及第 2 部分）連同清單中的所有項目郵寄至滙豐保險僱員福利索償 — 香港九龍中央郵政信箱70451號

WHAT HAPPENS NEXT 下一步

The process after you send in the claim form
提交此表格後的流程

1. The claim application of confinement must be submitted within 90 days after discharge.
   索償申請必須於出院後的 90 天內提出。
2. We'll let you know the outcome of this claim within 10 business days.
   我們將在 10 個工作日內通知您此索償的申請結果。
3. If you have any questions about your claim, please call (852) 3128 0153.
   如果您對索償有任何疑問，請致電(852) 3128 0153。
4. We'll contact you as soon as possible if we need more information, or if we need to have your claim assessed by a third party such as an impartial doctor or hospital. This could cause a delay to your claim. The employee or patient is responsible for any expenses incurred while the claim is being processed.
   如果我們需要更多資料，或者需要讓第三方（例如公正的醫生或醫院）評估您的索償，我們會盡快與您聯繫。這可能會導致您的索償延遲。受保僱員或病人需要支付索償期間產生的任何費用。

CHECKLIST 索償文件清單:

What you need to submit with this claim
您需要與此索償一起提交的文件
Note: a discharge summary can replace section 2 if the hospital stay was in a government hospital (managed by Hospital Authority, ward level).
注意：如果住院是在政府醫院（由醫院管理局管理之普通病房），則出院總結可以代替第 2 節。

- ☐ Copy of receipt(s) of the medical expenses (including deposit receipt)
  醫療費用收據副本（包括按金收據）
- ☐ Copy of Hospitalisation surgical package charges breakdown (if applicable)
  住院 / 手術套餐費細目副本（如適用）
- ☐ Copy of Laboratory test breakdown and amount
  化驗詳情及金額副本
- ☐ Copy of Drug list (include drug name, dosage, quantity and amount)
  藥物詳情副本（包括藥物名稱，劑量，數量及金額）
- ☐ Copy of Referral letter(s) for any specialists
  任何專科轉介信副本
- ☐ Copy of Histopathology, Laboratory Test Report, Endoscopic, Ultrasonogram, X-Ray, CT Scan, MRI, Diagnostic Written Report(s) and Operating theatre summary (if applicable)
  組織病理學，實驗室檢查報告，內窺鏡檢查，超聲檢查，X 射線，CT 掃描，磁力共振，診斷之書面報告和手術室摘要副本（如適用）
- ☐ Copy of Insured Employee / Patient's proof of identity such as ID Card, Passport or Birth Certificate etc.
  受保僱員/病人的身份證明副本，例如身份證，護照或出生證明等
- ☐ Copy of document with the Insured Employee / Patient's name and bank account details (if applicable)
  受保僱員 / 病人之個人本地銀行戶口證明文件副本 (如適用)

SECTION 1: CLAIM INFORMATION 甲部 – 索償資料

To be completed in BLOCK LETTERS and signed by the employee or patient 由受保僱員或病人填寫

1. MEMBERSHIP INFORMATION 成員資料

1A. EMPLOYER DETAILS 僱主資料

Group medical policy no. 團體保單編號	Refer to e-medical card on your Benefits+ App / Physical Medical Card 請參閱您的 Benefits+ App / 實體醫療卡上的成員編號	Employer name 僱主/團體保單投保公司名稱	

1B. EMPLOYEE DETAILS 僱員資料

Mandatory fields, otherwise, claim will not be processed 必須填寫，否則索償將不予處理

Full name 姓名	Phone no. 電話	Email 電郵
	852–	

1C. PATIENT DETAILS 病人資料

Name of Patient (if different from above) 病人姓名(如與上述不符)	HK/Macau ID card no. 香港/澳門身份證號碼	Membership no. 成員編號
	–	Refer To E-Medical Card On Your Benefits+ App / Physical Medical Card 請參閱您的 Benefits+ App / 實體醫療卡上的成員編號

2. MEDICAL SERVICE DETAILS FOR YOUR CLAIM 醫療服務詳情

2A. IF YOU'RE CLAIMING FOR AN ILLNESS 如您因患病而索償

Duration of symptoms 症狀持續時間	Description of illness symptoms 疾病症狀之描述

2. MEDICAL SERVICE DETAILS FOR YOUR CLAIM (CONTINUED) 醫療服務詳情（續）

2A. IF YOU'RE CLAIMING FOR AN ILLNESS (CONTINUED) 如您因患病而索償（續）

ATTENDING DOCTOR'S INFORMATION 主診醫生資料

(If this doctor is different from your regular doctor （如果這位醫生與您的常規醫生不同）

Have you had any previous treatment for this illness or a related condition? If yes, please provide more details. 您是否曾經接受任何此類或相關疾病的治療? 如是，請詳述之。 ☐ Yes 是 ☐ No 不是	Name 醫生姓名	Address 醫生地址	Date of Consultation DD/MM/YYYY 求診日期 DD/MM/YYYY

2B. IF YOU'RE CLAIMING FOR AN ACCIDENT 如您因意外而索償

Date & time of accident 意外日期及時間	Location of accident 意外地點	Can you provide details of how your injuries were caused by the accident? 您能詳細說明你是如何在事故中受傷的嗎？
DD日 MM月 YYYY 年 HR 時 : MIN 分 ☐ A.M 上午 ☐ P.M 下午		

3. PAYMENT INSTRUCTIONS 付款指示

☐ Cheque - made payable to the insured employee and mailed to their address.
支票 – 以支票支付受保僱員並將支票寄往其通訊地址。

☐ Bank account transfer - the insured employee's name must be on the bank account as the main or joint account holder. We need proof of this attached to this claim, otherwise we will mail a cheque instead.
轉賬至銀行戶口 - 必須為受保僱員之個人或聯名銀行戶口。請提供戶口證明，否則付款將以支票形式寄予受保僱員通訊地址。

Account no. 戶口號碼	Account holder name 戶口持有人姓名
Bank Code 銀行編號 – Branch Code 分行編號 – Account Number 戶口號碼	

We require a document including the Insured Employee's full name and bank account details attached to this claim as proof, otherwise we will mail a cheque instead. If you do not provide the bank proof, payment will be made by cheque payable to the Insured Employee and mailed to the Insured Employee's correspondence address.
請提供受保僱員本地銀行戶口證明文件副本並清楚顯示受保僱員全名和銀行戶口詳細信息作為索償的證明。若您未能提供銀行證明，我們將通過支票支付予受保僱員並郵寄到其通訊地址。

5. EMPLOYEE / PATIENT'S DECLARATION & AUTHORISATION 受保僱員或病人聲明和授權

I/We hereby certify that the answers and statement given above are true and complete to the best of my/our knowledge and that I/We have withheld no material fact. I/We authorise any physician, hospital, clinic, insurance company or other individual organisation or government office that has any records or knowledge of my/our health, to disclose to HSBC Life (International) Limited or its representative any information relevant to this claim. This authority shall remain valid notwithstanding my death or incapacity and a copy of this authorisation shall be as effective and valid as the original. By signing below, I/we confirm the above application and agree that the Company may use and disclose all personal data about me/us that the Company currently or subsequently hold for the purposes as set out in the Notice relating to the Personal Data(Privacy) Ordinance (which may otherwise be referred to as 'Personal Information Collection Statement') that the Company, HSBC Life (International) Limited, have most recently notified me of, and I understand I can scan the QR code on the right for review, or contact the Medical Services Hotline for details. The Company will collect, use, disclose and transfer my/ our and/or beneficiary's personal information, for the purposes necessary to detect and prevent fraud (whether or not relating to the policy mentioned in this form) to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: organisations that consolidate claims and underwriting information for the insurance industry; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information.
本人（等） 在此聲明以上所提供的資料均屬正確無訛且並無缺漏。本人謹此聲明, 本人已細閱並完全明白以上內容及本表格後頁的個人資料收集聲明 。本人(等)授權任何知道本人健康情況及據知任何紀錄之醫生，醫院，診所，保險公司或其他私人 ，政府機構向滙豐人壽保險(國際)有限公司或其代表提供本人(等)之有關資料 。 此授權書於本人(等)死亡或喪失能力後依然生效 。 本授權書之影印本亦屬有效。本人（等）在下方簽署即確認上述申請並同意 貴公司可按本表格隨附的關於個人資料（私隱）條例的通知內列出的用途使用及披露 貴公司現時或其後持有有關本人（等）的全部個人資料。該條例亦是 貴公司最近通知本人有關「個人資料收集聲明」，本人亦明白「個人資料收集聲明」可以掃瞄右方的二維碼瀏覽，或可聯絡醫療服務熱線以取得詳情。本人(等)及／或受益人的個人資料給以下人士，以用作偵測和防止欺詐行為(無論是否與就本表格而發出的保單有關)所需的目的，而他們只能在有合理需要履行上述目 的之情況下才可收集和使用這些資料：整合保險業申索和承保資料的組織；防欺詐組織；其他保險公司(無論是直接地，或是通過防欺詐組織或本段中指名的其他人士)；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊(及其運營者)。

Personal Information Collection Statement (English)

個人資料收集聲明 (中文)

6. PATIENT'S SIGNATURE 病人簽署

Signature of Patient/Parent or Legal Guardian(if Patient below 18 years of age) 病人簽署/家長或合法監護人簽署 (適用於十八歲以下之病人)	Full name (in BLOCK letters) 姓名（請以正階英文書寫）	HK/Macau ID Card no. 香港/澳門身份證號碼	Date signed 簽署日期
		–	DD日 MM月 YYYY年

SECTION 2: DOCTOR SECTION 乙部 – 由醫生填寫

To be completed in BLOCK LETTERS and signed by the consulting doctor. If the patient is confined in a government hospital (managed by Hospital Authority, ward level), discharge summary would replace the completion of this section of the form. 請以正楷填寫並由主診醫生簽署 (若索償人入住香港醫管局轄下公立醫院之普通病房，出院總結可替代索償表格之乙部)

1. PATIENT DETAILS 病人資料

Full name 病人姓名	Date of birth 出生日期	HK/Macau ID card no. 香港/澳門身份證號碼	Membership no. (required for the claim to be processed) 成員編號（此欄必須填寫否則索償申請將不獲辦理）
	DD日 MM月 YYYY年	–	

2. CLINICAL HISTORY 求診紀錄

Date of first consultation 首次看診日期	Description of patient's symptoms 病徵	How long has the patient shown these symptoms? 病人在首次求診前患有該病徵多久?
DD日 MM月 YYYY年		
Please list and provide reasons for any laboratory test(s)/ imaging test(s)/other diagnostic test(s) the patient required during their hospitalisation. 建議之化驗/影像檢查/其他診斷性檢查及接受該等檢查的原因。		

3. HOSPITAL AND SERVICES INFORMATION 住院詳情

Admission type
醫院/日間手術護理中心/醫療診所類型

- ☐ Inpatient 住院
- ☐ Hospital Outpatient Department 醫院門診部
- ☐ Day Case Procedure Center 日間中心
- ☐ Medical clinic 診所

Accommodation type
住院級別

- ☐ Private 私家房
- ☐ Semi-private 半私家房
- ☐ Ward 大房
- ☐ Hospital day ward 醫院日症
- ☐ Medical clinic 醫療診所

Please provide details of treatment, treatment sessions, tests conducted, on-going treatment and recovery plan below.
請提供是次住院詳情，包括相關治療，檢查 ，測試結果，持續治療及康復計劃 。

Date of treatment /admission and discharge 治療日期/ 入院及出院日期	Final diagnosis / ICD-10 Code 最後的診斷/國際疾病分類代碼	Type of surgery or treatment administered 手術或治療名稱	Did the patient leave the hospital at any point during their admission? 病人是否於住院期間離院?	Please provide reasons for the length of the hospital stay, including the reason for the number of days as an inpatient 請提供是次持續留院日數及其原因
Date of treatment /admission 治療/入院日期 DD日 MM月 YYYY年 Date of discharge 出院日期 DD日 MM月 YYYY年			☐ Yes 是 ☐ No 不是 If yes, please fill in the date 如是，請填寫日期 DD日 MM月 YYYY年	

Has the patient been consulted by other Physician(s)/Surgeon(s) during this hospitalisation? 病人曾否於住院期間向其他醫生求診?	☐ Yes 是 ☐ No 不是 If yes, please provide information below. 如果選擇是，請在下方填寫信息。

Name of Physician(s)/Surgeon(s) 醫生姓名	Reason 原因	Treatment performed 治療詳情

4. CANCER TREATMENT 癌症/腫瘤相關治療

Type of treatment administered
治療種類

- ☐ Surgical 外科治療
- ☐ Chemotherapy 化療
- ☐ Hormonal Therapy 荷爾蒙治療
- ☐ Target therapy 標靶治療
- ☐ Radiotherapy 電療
- ☐ Immunotherapy 免疫療法
- ☐ Others 其他 _____

Name of drug administered 藥物名稱	Dosage 藥物劑量	Frequency of dosage 治療頻率	Duration of treatment 持續治療的時間	If the patient suffered any complications during treatment, please provide details. 如病人接受治療期間出現併發症，請詳述之。

5. MEDICAL DIAGNOSIS AND ADVICE 診斷詳情

Can medical tests and procedures be done on an outpatient basis / at a Day Case Procedure Centre?
該檢查及手術可否在門診/日間手術中心進行?

☐ Yes 是 ☐ No 不是

If yes, please provide details for the reason. 若可以，請說明病人住院的原因。
If no, please give a reason for the hospital stay. 若不可以，請詳述之。

Was it an emergency hospitalisation or procedure?
這是否緊急個案？

☐ Yes 是 ☐ No 不是

If yes, please provide more details.
如是，請詳述之。

Was the current condition due to one of the following?
上述情況是否與以下問題有關?

- ☐ Accidental bodily injury 意外身體受傷
- ☐ Self-inflicted injury 自我傷害
- ☐ Abuse of drugs or alcohol 濫用藥物或酒精
- ☐ Infertility or sterilisation 不育或絕育
- ☐ Contraception 避孕
- ☐ Treatment for cosmetic purpose 美容性質的治療
- ☐ Vaccination 疫苗接種
- ☐ Pregnancy 懷孕
- ☐ Congenital condition 先天性疾病異常
- ☐ Mental disorder 精神紊亂
- ☐ Refractive error 屈光不正
- ☐ Developmental condition 發育問題
- ☐ Hereditary condition 遺傳性問題
- ☐ General check-up 一般身體檢查

In your opinion, was the hospitalisation a result of a recurring / chronic illness or related to a previous condition?
您認為是次住院是因為複發性/長期疾病或之前的疾病?

☐ Yes 是 ☐ No 不是

If yes, please give more details on the recurring / chronic illness or previous condition below.
如是，請在下方提供細節。

Date 日期	Details on the recurring / chronic illness or previous condition. 請說明細節

Is everything being claimed on this form medically necessary and recommended for the patient's current diagnosis?
是次檢查 ， 治療及住院日數(如有)是否和上述診斷有直接關係而且是醫療所需及由醫生建議？

☐ Yes 是 ☐ No 不是

6. MEDICAL HISTORY 病歷紀錄

Has the patient previously suffered from related conditions to this illness? 病人曾否出現與此疾病相關的徵狀?	☐ Yes 是 ☐ No 不是 If yes, please provide information below. 如是，請在下方提供細節。

Date of doctor's consultation or hospital admission DD/MM/YYY 醫生就診或住院日期 DD/MM/YYY	Name of doctor 醫生姓名	Patient's symptoms 病徵	Diagnosis / ICD-10 Code 診斷/國際疾病分類代碼	Name of treatments administered (Add details of any past or upcoming surgical procedure/s) 所提供的治療 (請列明已接受或將會進行的手術名稱)

7. DOCTOR INFORMATION 醫生資料

7A. REGULAR DOCTOR'S INFORMATION 慣常醫生資料

Are you the patient's regular doctor? 您是否該病人的慣常醫生?	☐ Yes 是 If yes, please proceed to section 7B. 如是， 請跳至7B。 ☐ No 不是 If no, please provide patient's regular doctor's information below. 如不是，請提供醫生姓名、地址和電話號碼。

Full name 姓名	Address 地址	Phone no. 電話號碼

7B. REFERRED DOCTOR'S INFORMATION 轉介醫生資料

Is the patient referred by another doctor? 病人是否由其他醫生轉介?	☐ Yes 是 ☐ No 不是 If yes, please provide the referring doctor's information below. 如是，請提供轉介醫生的姓名、地址和電話號碼。

Full name 姓名	Address 地址	Phone no. 電話號碼

8. DOCTOR'S DECLARATION AND AUTHORISATION 醫生聲明及授權書

I declare that all information provided is true and complete to the best of my knowledge.
本人謹此聲明及同意上述一切陳述及問題的所有答案，就本人所知所信，均為事實全部並確實無訛 。

Name of attending doctor (Please add your qualifications) 主診醫生姓名 (請提供您的專業資格)	Address 地址	Phone no. 電話號碼

DOCTOR'S SIGNATURE 醫生簽署

DD日 MM月 YYYY年

Signature and stamp of attending doctor
主診醫生簽名及蓋章

Date signed
簽署日期